DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-18**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2003-2004 $ 26,291,655
b. FFY 2004-2005 $ 37,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Part 1, Pages 1-20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Part 1, Pages 1-20

10. SUBJECT OF AMENDMENT:
This transmittal is being submitted to change the methodology used to calculate nursing facility Medicaid payment rates.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Lynn Read for JN

13. TYPED NAME: Lynn Read Jean Thorne

14. TITLE: Administrator, OMAP Director, DHS

15. DATE SUBMITTED: 10-16-03

16. RETURN TO:
Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor, E35
Salem, OR 97301

ATTN: Carole Van Eck

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT 16 2003

18. DATE APPROVED: MAY 26 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL: Dennis Smith

21. TYPED NAME: Dennis Smith

22. TITLE: Director

23. REMARKS:

FORM HCFA-179 (07-92)

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

A. Reimbursement by the Senior and Disabled Services Division of the Department of Human Resources (Division) is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payor are not allowed;

B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;

C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;

D. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit: and

E. A proportionate share incentive adjustment to non-State operated governmental nursing facilities; and

F. Annual review and analysis of allowable costs for all participating nursing facilities.

II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.

2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.

3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility requires one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division shall pay the basic rate plus the complex medical add-on rate to a provider as prospective payment in full.

2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid resident of a nursing facility whose care is reimbursed at the basic rate if the resident needs one or more of the following medication procedures, treatment procedures or rehabilitation services:

   a. Medication Procedures

      (1) Administration of medication(s) requiring skilled observation and/or judgment daily or more often for necessity, dosage and/or effect (This category does not cover routine oral medications or the use of oral antibiotics or the infrequent adjustments of a current stabilized medication routine);

      (2) Intravenous injections/infusions, heparin locks daily or more often for hydration or medication;

      (3) Sliding scale insulin injections daily or more often;

      (4) Intramuscular medications for unstable condition daily or more often;

      (5) External infusion pumps daily or more often if resident cannot self-bolus;

      (6) Hypodermoclysis daily or more often; or

      (7) Peritoneal dialysis daily or more often when resident unable to do own exchanges;

b. Treatment Procedures

(1) Nasogastric, gastrostomy/jejunostomy tubes daily or more often for feedings;

(2) Nasopharyngeal suctioning two times daily or more often and/or tracheal suctioning as required for a resident who is dependent on nursing staff to maintain airway;

(3) Percussion, postural drainage, and aerosol treatment when all three are performed two times daily or more often;

(4) Care and services for a ventilator dependent resident who is dependent on nursing staff for initiation, monitoring, and maintenance;

(5) Stage III or IV decubitus ulcers or ulcers related to circulatory impairment which require aggressive treatment and are expected to resolve;

(6) Open wound(s) which require aggressive treatment and are expected to resolve;

(7) Deep or infected stasis ulcers with tissue destruction equivalent to Stage III (eligibility for add-on retained until resolved or returned to previous chronic status);

(8) Short term, professional teaching implemented to satisfy a discharge or self-care plan;

(9) Emergent medical/surgical problems requiring short term professional nursing observation and/or assessment with approval from the Resident Care Review Specialist (eligibility for add-on retained until resident no longer requires professional observation and assessment for this medical/surgical problem); or

(10) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning (eligibility for add-on retained until resident no longer requires professional observation and assessment for this medical problem);

c. Rehabilitation Services

(1) Physical therapy performed at least 5 days every week;

(2) Speech therapy performed at least 5 days every week;

(3) Occupational therapy performed at least 5 days every week;

(4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or

(5) Respiratory Therapy authorized by Medicare, Medicaid Oregon Health Plan or a third party payor and performed by a respiratory therapist at least 5 days every week.

3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.

C. Pediatric Rate.

1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. the Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.

3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.

2. Swing Bed Eligibility. To qualify for a complex medical needs add-on payment, a hospital shall:

   a. Be approved by HCFA to furnish skilled nursing care as a Medicare swing bed hospital;

   b. Enter into a Medicare agreement to provide acute care; and

   c. Enter into an agreement with the Division to receive Medicaid payment for swing bed services.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located, the Division shall pay the lesser of:

   a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or

   b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment or an Extreme Outlier Client Add-on payment, or the pediatric rate.

4. Extreme Outlier Client Add-On.

a. The Division shall make an outlier client add-on payment when a ventilator-dependent client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

b. The add-on will be specific to the client's care needs, based on an extreme outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.

c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible Medicaid portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Minimum Wage Add-on.

   a. The Division shall add to the basic rate and the pediatric rate a minimum wage add-on payment to reimburse facilities for the cost of implementing changes in the Oregon minimum wage law:

      (1) From $4.75 to $5.50 effective January 1, 1997;

      (2) From $5.50 to $6.00 effective January 1, 1998; and

      (3) From $6.00 to $6.50 effective January 1, 1999.

   b. The minimum wage add-on to be paid from July 1, 1997 to June 30, 2001 will be calculated as a weighted average add-on paid in addition to the basic rate and the pediatric rate based on payroll data for December 1996, September 1998 and September 1999 supplied by nursing facilities.

8. Proportionate Share Incentive Adjustment.

   a. The Division recognizes that non-State operated governmental nursing facilities provide care to many clients who are medically complex and fragile.

   b. The Division will ensure continued access to this level of care through proportionate share incentive adjustment payments to each non-State operated governmental nursing facility.

   c. The proportionate share incentive adjustment shall be paid at least

annually for each State Fiscal Year. The payment to each facility is in proportion to the facility's Medicaid days during the cost reporting period that ended immediately preceding the State Fiscal Year relative to the sum of all Medicaid days during the same period for facilities eligible and participating in the adjustment. The total funds for the incentive payment are established each State Fiscal Year subject to the anticipated level of nursing facility payments within the year and to the payments limits of 42 CFR 447.272.

III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Flat Rate and Complex Medical Needs Add-on Rate.

A. Financial Reporting and Facility Auditing.

1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.

2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.

B. Calculation of the Standard Statewide Flat Rate and Complex Medical Needs Add-on Rate.

Effective July 1, 1997 and through June 30, 1999 (the 1997/99 biennium),